# Committee on Resources

## Witness Testimony

Statement of Buford L. Rolin

Chairman

National Indian Health Board

On H.R. 1833, a Bill to amend the Indian Self-Determination

and Education Assistance Act

March 17, 1998

Chairman Young, Vice Chairman Miller, and distinguished members of the U.S. House Committee on Resources, I am pleased to offer testimony on behalf of the National Indian Health Board (NIHB) on H.R. 1833, which amends the Indian Self-Determination and Education Assistance Act to provide for further self-governance by Indian Tribes, and for other purposes. The NIHB represents all 554 Tribal governments in advocating for the improvement of health care delivery. Our Board Members represent each of the twelve Indian Health Service Areas, and are generally elected at-large by Tribal governmental officials within their respective regional Areas.

The NIHB has a duty to represent the sovereign right of all Tribal governments to promote the highest levels of health for American Indians and Alaska Natives, and to advise the federal government in the development of responsible health policy. It is my understanding that more than 800 treaties, executive orders, and statutes were negotiated between the United States and our native ancestors. These ancestors were men and women who shed blood and witnessed the massacre of their people, by the U.S. Army and other non-Natives who sought to carry out "Manifest Destiny". American Indian and Alaska Native governments were forced to turn over more than 450 million acres of land with the promise that their sovereign nationhood would be preserved. In exchange for this precious land, which had sustained for them a quality lifestyle, our Indian leaders were promised health care, education, housing, and other forms of federal assistance, all intended to enable Indian people to retain their self-sufficiency.

Much of what was promised has historically not been provided, and many of our people have since then fallen out of self-sufficiency. This fact is well documented. As a result of the initiative of many Tribal leaders, the historical preference of the legislative branch of the United States government that self-sufficiency of tribes be fostered and encouraged, and the foresight of the presidential administration at that time, the Indian Self-Determination and Education Assistance Act was enacted into law in 1975 as P.L. 93-638. Under this Act, and the many subsequent amendments, the process by which Tribes may manage their own affairs has developed into a viable option for Tribes to take care of themselves. After all, are not the tribes, as a local form of government, best suited to take care of their own people, if they only have the resources to do so?

What I would like to share with you today is that the policy of Self-Determination and Self-Governance is

working out very well. This point is borne out by the experience of my own Tribe, by the Tribes of many other Tribal leaders with whom I have frequent contact, and, as I will discuss today, by a study recently finished by the National Indian Health Board.

**NIHB POSITION ON H.R. 1833**

Before I comment on the specific findings of this national study, I want to convey the position of Tribal Governments on the merits of H.R. 1833. When the National Indian Health Board met on January 15th to 17th, 1998, a presentation was made to the Board of Directors on the proposal to permanently establish the Self-Governance program within the Indian Health Service. Bearing this information, each of our Board Representatives were to return to the twelve Areas of the Indian Health Service to elicit the position of their respective Tribal Governments on whether these governing authorities supported the present legislation permanently authorizing Self-Governance as a policy within the Indian Health Service. It was determined that this policy matter would be discussed by the NIHB at it's next Board meeting to be held on April 2nd to 4th, 1998.

As of Friday, March 13, 1998, we have received resolutions from four Areas: the Alaska Native Health Board; California Rural Indian Health Board, the Montana-Wyoming Health Board, and the United South and Eastern Tribes, which collectively represent the support of 291 Tribal Governments. Upon polling the Board Representatives of the remaining eight Areas of the Indian Health Service, we understand that seven Areas will be meeting before April 2nd, 1998 and will convey the sentiments of their Tribes at the upcoming Board Meeting. We have not yet been apprised of the position of the Aberdeen Area Tribes and understand they will offer testimony at this House Hearing as to their stance on the policy of Self-Governance. While I cannot offer a firm position of the National Indian Health Board on support for or against H.R. 1833 today, I respectfully request your permission to submit the views of the NIHB immediately after our Board meets on April 6th, 1998. At that time, our organization will supply the House Resources Committee with any suggested technical amendments to H.R. 1833 if deemed appropriate.

**NATIONAL STUDY ON SELF-DETERMINATION AND SELF-GOVERNANCE**

With funding from the Administration for Native Americans and the Indian Health Service, the NIHB has gathered and summarized information on the effects of tribal control of health care programs from those in the most appropriate position to evaluate the impacts: the tribes themselves.

The purpose of the study was to explore from a tribal perspective how Self-Determination and Self-Governance were working, and what could be done to further the policy. The final report includes a financial analysis, as well as an assessment of the changes in services and facilities, management changes and challenges, and the impacts on quality of care. The study also considered the opportunities and barriers to contracting and compacting, the issue of tribal sovereignty, future trends, and recommendations from tribal leaders.

**RESEARCH APPROACH**

Four different types of research were conducted: 1) review of previous studies; 2) financial analysis using the Department of Health and Human Services (DHHS) Financial Data System; 3) survey of tribes; and 4) analysis of training needs. An Advisory Committee was formed to help guide the development of the tribal survey and to review draft reports.

The survey of tribes was the most critical element of the study, since it provided the tribal perspectives necessary to accomplish the goal of the study: evaluating the impacts of tribal choices in health care. Two surveys were conducted, one of tribal leaders and one of tribal health directors. The questionnaire used to survey tribal leaders was intended to be brief and policy-oriented. The health directors questionnaire was longer, and it requested more detailed quantitative information.

A total of 210 tribes and tribal organizations participated in this study. This represents 36 percent of the 587 tribes and tribal organizations that received questionnaires. It is about 38 percent of the 554 federally-recognized tribes.

Every IHS administrative Area was represented in the study. The rate of participation by tribes within the Areas ranged from 24 percent to 100 percent.

For the tribal leader survey, 171 questionnaires were received. This is 29 percent of the total 587 mailed and 31 percent of the 554 federally-recognized tribes. Tribal leaders from every Area participated with a response rate ranging from 16 percent to 100 percent by Area. Tribal leaders from every type of tribe participated, with 40 from IHS direct service tribes, 36 from contracting tribes and 95 from compacting tribes.

The health director survey was sent to 256 people in 239 organizations. A total of 71 questionnaires were received representing 30 percent of the organizations. Every Area was represented, with response rates ranging from 15 percent to 100 percent. Health director questionnaires were received from 21 IHS direct service tribes, 31 contracting tribes and 19 compacting tribes.

Overall, the survey sample appears to be representative of the whole. Where responses from an Area are low, they have been combined with those from other Areas to form larger groups for some types of analysis. It should be noted that this survey presents a tribal perspective giving equal weight to every federally-recognized tribe regardless of the number of members enrolled or the amount of the IHS budget allocated to the tribe or the number of facilities serving the tribe.

## CONCLUSIONS OF THE STUDY

The study provided the opportunity to survey a broad cross-section of tribal leaders and health directors from every Area of the IHS and every type of health care delivery system. In combination with financial analysis, the information obtained provides a quantitative and qualitative assessment of the impacts of self-determination contracting and self-governance compacting on the system of health care services for American Indians and Alaska Natives. It is significant because it offers a tribal perspective on the changes that have occurred in the past 3-4 years in which tribal self-governance demonstration projects have become part of the landscape of Indian Country. Evidence presented in this study suggests the following conclusions:

**The federal policy of self-determination contracting and self-governance compacting is working, but it could be improved.** Overall, self-determination is working in that tribes that have chosen to manage their health care programs are very successful. However, a significant number of leaders of IHS direct service and contracting tribes felt that they had no choice, or that their choices were more limited than the law provides. Furthermore, the lack of Indian Self-Determination (ISD) contract support funding is preventing some tribes from exercising their options.

**The health of American Indian and Alaska Native people has improved at the same time that there has been a growth in tribal management of programs.** Numerous indicators show that the health status of American Indian and Alaska Native people has improved, and there is no direct evidence that tribal management has caused a decline in the health status of American Indians and Alaska Natives. In fact, tribal management has led to many improvements in the health systems that serve these communities, and many of these improvements are illustrated in the results of this study.

**On average, every type of tribe - IHS direct service, contracting, and compacting - has achieved a higher level of health care since the self-governance demonstration project began.** Tribally-managed programs have an even better track record than IHS direct service programs in the addition of new services and facilities. Clearly, some tribes feel that their services and facilities have suffered due to a combination of problems, including population growth, inflation, and unfunded mandatories. Most tribes in the study, even those that have seen dramatic improvements, feel that there are many more health care services needed and that this requires greater funding by Congress.

**When tribes assume control of health care, they give a high priority to prevention programs.** When tribally-operated programs have had the opportunity to add or expand services, prevention has been the leading area for expansion. When forced to eliminate programs, IHS direct service was more likely to eliminate prevention services than tribally-operated programs.

**Tribes more commonly perceive an improvement in the quality of care when they manage their own health care systems.** Tribal leaders and tribal health directors in this study more commonly rated the quality of care over the last 3 - 4 years as "better", especially if they represented compacting tribes. In addition, the tribal leaders and health directors that rated the quality of care as "worse" were more commonly from IHS direct service tribes.

**Population growth and inflation have reduced the purchasing power of Congressional appropriations for Indian health.** Despite slight increases in actual Congressional appropriations, there has been an 18 percent decline in the adjusted per capita expenditures, or purchasing power, of IHS dollars from FY 1993 to FY 1998. This reduction is affecting all types of tribes in all Areas of the IHS. A significant increase in Medicaid rates provided some relief during the period of this study.

**Tribes do not have more difficulty than the IHS in recruiting and retaining health care professionals.** Recruitment and retention of health professionals is a problem for all parts of the Indian health system, due in large part to location of health facilities in remote, rural areas. Tribes report fewer problems recruiting health care professionals than the IHS direct service programs. There appears to be little difference in retention of health care professionals between IHS direct service Tribes and Tribally-operated programs.

**The motivation for compacting is not just increased funding.** When tribal leaders were asked the reasons they chose their form of health care management, a majority of leaders of compacting tribes cited tribal sovereignty and local control. Other reasons included management flexibility to meet the needs of tribal members and the opportunity to improve the quality of care. Only 7 percent cited maximizing funding.

**As the federal system of Indian health care changes, integration of services is occurring through tribally-controlled organizations.** While tribes want more local control, many tribes are improving efficiency by entering into multi-tribal agreements for purchasing and delivering services. Multi-tribal agreements are expected to increase in the next five years according to the tribal leaders.

**Self-governance compacting is not hurting most other tribes.** While many tribes in this study said that they were hurting from lack of adequate federal funding, few reported that they were hurting as a result of other tribes compacting. The direct negative consequences that were reported were the loss of discretionary funds to cover budget shortfalls at the end of the year and the shift of some responsibilities to the Service Unit level. Overall, most of the tribes that were not compacting reported improvements in services, management, and quality of care.

**The federal government could do more to assure tribes that self-determination contracting and self-governance compacting will not lead to termination.** Many tribal leaders who participated in this study would feel more comfortable about the future if there were changes at the federal level to protect their sovereignty. They types of changes suggested include laws, funding approaches, flexibility in regulations, increased consultation, and more training in Indian law for Congress and federal employees.

**The trend toward increased self-determination contracting and self-governance compacting will make the Indian health system look different in five years.** If tribes make the changes they predict in this study, the Indian health system will have 6 percent of tribes receiving IHS direct services, 38 percent of tribes contracting, and 56 percent compacting. While these projections are based on the definitions used in this study, the indication by tribes is clear that they plan to exercise more control over their health care delivery systems.

**More research is needed on the effects of tribal management on Indian health.** Follow up studies are needed to more fully explore some of the issues identified in this report. It is important to continue the work begun by the Indian Health Service Baseline Measures Workgroup to further define ways of measuring quality of care indicators so that data may be aggregated nationally, by region and/or by type of tribe for purposes of monitoring trends and comparing performance. While the financial information presented in this report provides a quantitative assessment of the impacts of contracting and compacting, the picture will certainly continue to change and it is necessary to monitor those changes. The changes in the system predicted by the tribal leaders should be monitored in the context of changes in federal policies that affect barriers and opportunities.

**If the Federal government wants to encourage Tribal management, policies could be changed to remove barriers and increase opportunities**. According to the findings of this study, these could include:

Full funding for both direct and indirect costs for Tribal management of health services;

Remove limits on the number of compacting tribes

More training available locally to provide entry for Tribal members into health careers;

More training and technical assistance to help tribes acquire and maintain management expertise; and

Changing attitudes in those few IHS Area Offices where tribes perceive that compacting is discouraged.

## CONCLUDING REMARKS

On behalf of the National Indian Health Board, I thank the Committee for considering our testimony on the success of Self-Governance in health care in Indian Country. As you can see, the National Indian Health

Board has determined that Self-Determination and Self-Governance is working out, and has identified ways to make it work even better. I urge you to keep these findings in mind as you consider making the Self-Governance program permanent for Indian health, and as you consider the form such legislation will take.

I call upon my American Indian and Alaska Native friends and peers to work together with the House of Representatives to help attain the goals our ancestors sought to acquire for us; to ensure that it is possible for all of our Tribes to redevelop the ability to take care of their own people. Not one of us can return to our people back home on Reservations, on Pueblos, or in Native Villages without a commitment to doing all we can to improve the health of our people to the best of our ability.

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